Patient Safety in the AMEDD

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Objectives

- Briefly Review Key Patient Safety Concepts and Program Definitions
- Discuss Components of the AMEDD Patient Safety (PS) Program
- Provide Overview of Joint Commission (JC) Patient Safety Standards and 2004 National Patient Safety Goals

Definition

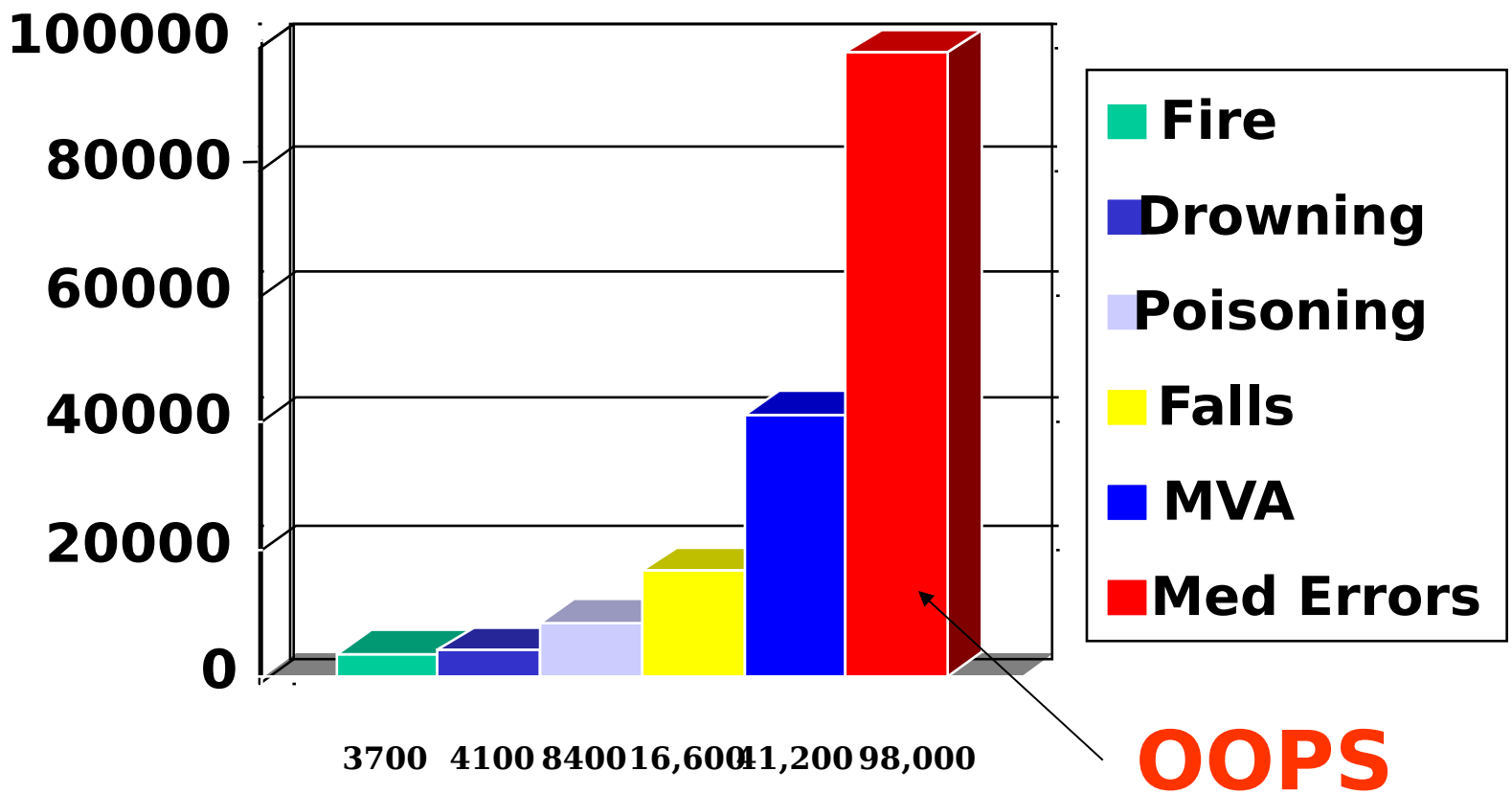
Patient Safety

Actions undertaken by individuals and organizations to protect health care recipients from being harmed by the effects of health care services.

Why the Focus on Patient Safety?

- **Right Thing to Do!**
  - ✓ Saves lives, saves money
- **Response to the "Deadly Secret"**
  - ✓ IOM Report - To Err is Human
    - 44,000-98,000 deaths due to medical error
    - National Cost: $17-29 Billion/year
    - 10-35% suffer from preventable adverse drug events cost hospitals $2 Billion/year
- Federal Mandate & Regulatory Requirement
  - ✓ Presidential Directive, NDAA, DoDI, DoD IG
  - ✓ JCAHO requirements

Deadly Secret



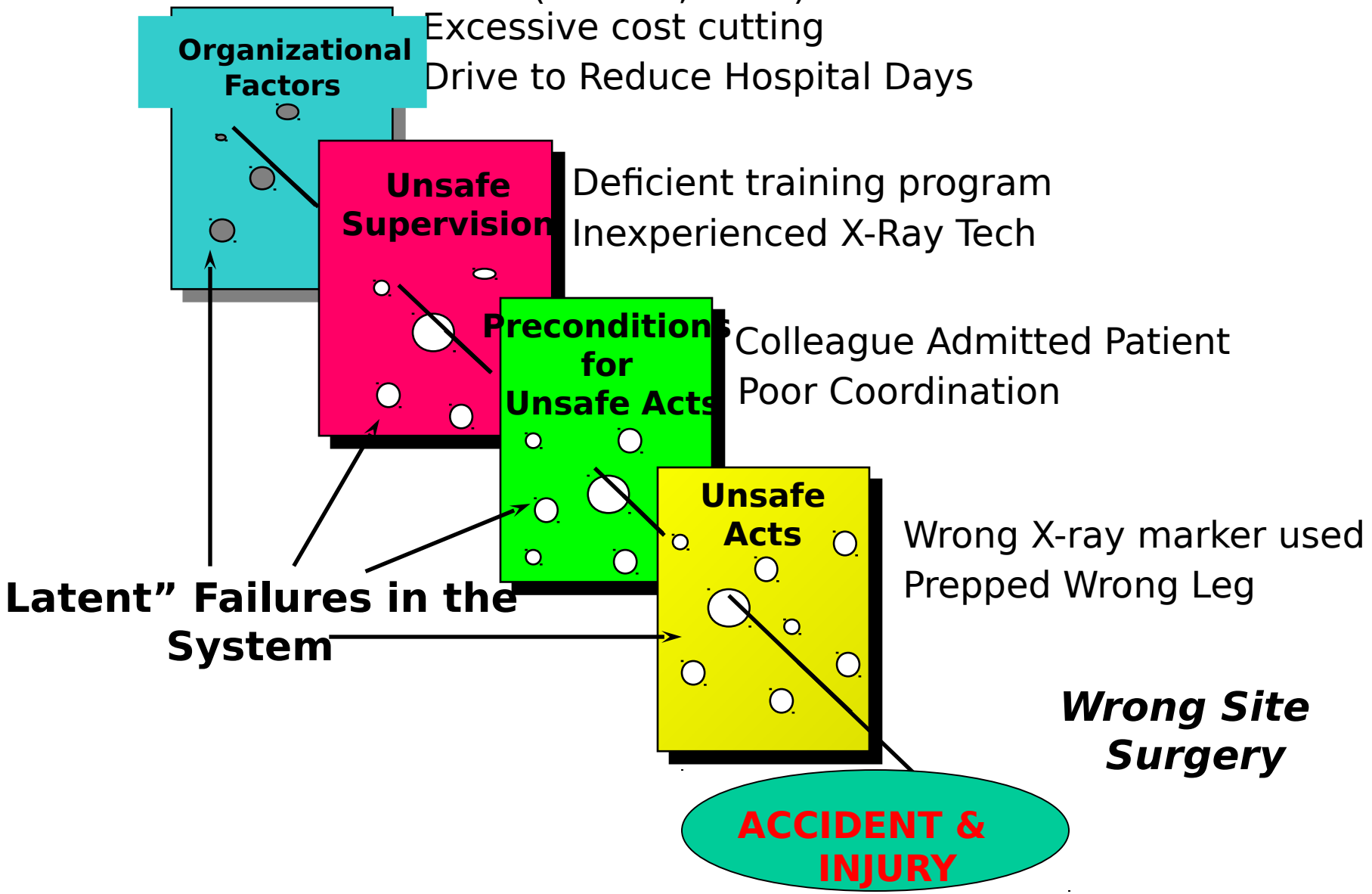
Program Goals

- Reduce chance of human error reaching & harming patients
- Promote culture to facilitate reporting
- Focus on system/process design **NOT** individual involved
- Ask What happened & Why **NOT** **Who…**

‘Paradigm Shift’ from current practice!

The “Swiss Cheese” Model of Accident Causation

(Reason, 1990)



Current Reality

- **Error prevention is often hampered by:**
  - ✓ Lack of clear lines of authority, accountability and responsibility
  - ✓ Fragmented approaches spread out over multiple bodies, committees, departments and individuals
  - ✓ Incidence of errors are severely under-reported due to:
    - Fear of reprisal
    - Ineffective and limited reporting mechanisms
    - Insufficient aggregate data to analyze and make decisions

Culture & Reporting

- Cultural Change Needed
  - ✓ Encourage institutional learning from errors
  - ✓ Focus on systems and processes
  - ✓ Minimize individual blame
  - ✓ Promote voluntary reporting of errors

Safe System Design

Process Design

- Reduce reliance on memory and vigilance
- Simplify
- Decrease Variation
- Checklists
- Forcing functions
- Eliminate look & sound a-likes

Organizational Change

- Increase feedback
- Teamwork
- Drive out fear
- Leadership commitment
- Improve direct communication

Patient Safety
&
The Joint Commission

Patient Safety Program Survey Expectations

- **MTF-wide PS Program Implementation**
  - ✓ 1 year ‘track record’ - 1 July 02
- **“Annual” Requirements:**
  - ✓ Select high-risk process
  - ✓ Complete 1st Annual FMEA – 1 July 01- 1 Sep 02
  - ✓ Complete 2nd Annual FMEA – 1 Jul 02 – 1 Jul 03
  - ✓ Start on number 3 - 1 Jul 03 – 1 Jul 04
  - ✓ Implement PS Goals - 1 Jan 03

Survey Process Overview

- **Patient safety primary focus**
  - ✓ Leadership interviews to evaluate if Patient Safety is an organizational priority
  - ✓ Onsite survey agenda reflecting emphasis on Patient Safety
  - ✓ Pt unit visits and staff interviews evaluate actual practice and performance
    - Tracer Methodology

Patient Safety
&
Health Literacy

Health Literacy

- **What is Health Literacy?**
- **Do we have a problem with Health Literacy?**
- **What can you do to help?**

Patient Safety
&
MEDCOM

AMEDD Leading the Way!

- **MEDCOM Regulation 40-41: The Patient Safety Program**
  - ✓ Establishes “Standardized” Corporate Program (Currently under revision)
  - ✓ Supports all Regulatory Requirements
    - Specific implementation guidance for
      - DoD Instruction 6025.17
      - NDAA 2001
      - JCAHO PS Standards

Make the Safest Way the Best Way!

Definitions of Terms

- **<u>Patient Safety (PS) Event</u>**
  - ✓ Incident that occurred (actual event) ***or*** almost occurred (close call/near miss) that caused or had the potential to cause harm to a patient
- **3 Types of PS Events**
  - ✓ Close Call/Near Miss
  - ✓ Adverse Event
  - ✓ Sentinel Event

Near Miss*

Any process variation or error that could have resulted in harm to a patient, visitor or staff, but through chance or timely intervention did not reach the individual. Such events have also been referred to as ‘close call(s)’

***Per DoD PS Planning & Coordination Committee (PSPCC) as of Jan 03**

Adverse Event

- **Occurrence associate w/ provision of health care or services that may *or* <u>may not</u> result in patient harm**
  - ✓ Acts of commission or omission

- ****Patient falls or improper medication administration, even if NO patient harm, fall into this PS event category**

Sentinel Event

Unexpected occurrence involving death, serious physical or psychological injury, “or risk thereof”

JC Reviewable Sentinel Events

- **Applies to recipients of care**
- **Applies only to events that meet the following criteria:**
  - ✓ Event resulted in unanticipated death or major permanent loss of function
  - ✓ Not related to the natural course of illness

OR

JC Reviewable Sentinel Events

- Suicide in a 24-hour Care Setting
- Infant Abduction/DC Wrong family
- Rape (by another pt, visitor, staff)
- Hemolytic Transfusion Reaction
- Surgery Wrong Patient/Body Part
- Unanticipated death of a full term infant

Other JC "Reviewable" Sentinel Events

- **Medication Error** resulting in Death, Paralysis, Coma or other Permanent Loss of Function
- **Maternal Death** (Intrapartum/Related to Birth Process)
- **Fall** resulting in Death or Permanent Loss of Function (Direct Result of Sustained Injuries)
- **Fatal Nosocomial Infection** considered SE and is reviewable
- **Surgical Fires** SE Alert #29

JC SE Statistics

(From Jan 95 – Dec 04)

current as of 22 February 2005

- **2966 Sentinel Events Reviewed by JC**
- **Categories of SE's to date include:**

415 Patient Suicide
370 Wrong-Site Surgery
365 Op/post-op Complication
326 Medication Error
221 Delay in Treatment
144 Patient Fall
124 Restraint Death/Injury
107 Assault/Rape/Homicide Abduction/wrong families
85 Transfusion Error
84 Perinatal Death/Loss Function
57 Patient Elopement
57 Infection –Related Event
51 Fire
49 Anesthesia-related Event
39 Ventilator Death/Injury
38 Maternal Death
37 Med Equip Deaths
21 Infant
18 Utility Systems-related Event
258 Other loss

Identified Root Cause/ Contributing Factors

JCAHO

1. Communication*
2. Orientation/Training*
3. Patient Assessment
4. Availability of Information
5. Staffing Levels*
6. Physical Environment
7. Competency/Credentialing
8. Procedural Complications
9. Alarm Systems

DoD

1. Communication*
2. No Policy/Procedure
3. Policy/Procedure not Followed
4. Inadequate Documentation
5. Lack of Training*
6. Staffing Levels*
7. Lack of Experience
8. Equipment Malfunction/ Availability

Communication

We know that communication is a problem, but we're not going to discuss it with the troops!

Systems Evaluation
(JC Minimum Scope of RCA)

- Patient Assessment
- Patient Identification
- Care Planning Process
- Availability of Information
- Orientation & Training
- Competence Assessment/ Credentialing
- Staff Supervision
- Staffing Levels
- Equipment Maintenance/ Management
- Technological Support
- Communication
  - ✓ Between Staff
  - ✓ Patient/Family
- Control of Medications
  - ✓ Storage/Access
  - ✓ Labeling
  - ✓ Security Systems/Processes

Root Cause Analysis (RCA)

A process for identifying the basic and causal factors that underlie variation in performance, to include the occurrence or possible occurrence of a sentinel event

Patient Safety
&
JCAHO National Patient Safety Goals for 2005

JC National Patient Safety Goals

- Originally Published 24 July 02
- Effective 1 Jan 05
  - MTFs must be in compliance

2005 Hospitals' National Patient Safety Goals

- **Goal: Improve the accuracy of patient identification.**
- Use at least two patient identifiers (neither to be the patient's room number) whenever administering medications or blood products; taking blood samples and other specimens for clinical testing, or providing any other treatments or procedures.

2005 Hospitals' National Patient Safety Goals

- **Goal: Improve the effectiveness of communication among caregivers.**
- ✓ For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the order or test result "read-back" the complete order or test result.
- ✓ Standardize a list of abbreviations, acronyms and symbols that are not to be used throughout the organization.
- ✓ Measure, assess and, if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values.

2005 Hospitals' National Patient Safety Goals

- **Goal: Improve the safety of using medications.**
- ✓ Remove concentrated electrolytes (including, but not limited to, potassium chloride, potassium phosphate, sodium chloride >0.9%) from patient care units.
- ✓ Standardize and limit the number of drug concentrations available in the organization.
- ✓ Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used in the organization, and take action to prevent errors involving the interchange of these drugs.

2005 Hospitals' National Patient Safety Goals

- **Goal: Improve the safety of using infusion pumps.**
- Ensure free-flow protection on all general-use and PCA (patient controlled analgesia) intravenous infusion pumps used in the organization.

2005 Hospitals' National Patient Safety Goals

- **Goal: Reduce the risk of health care-associated infections.**
- ✓ Comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.
- ✓ Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection.

2005 Hospitals' National Patient Safety Goals

- **Goal: Accurately and completely reconcile medications across the continuum of care.**
- ✓ During 2005, for full implementation by January 2006, develop a process for obtaining and documenting a complete list of the patient's current medications upon the patient's admission to the organization and with the involvement of the patient. This process includes a comparison of the medications the organization provides to those on the list.
- ✓ A complete list of the patient's medications is communicated to the next provider of service when it refers or transfers a patient to another setting, service, practitioner or level of care within or outside the organization.

2005 Hospitals' National Patient Safety Goals

- **Goal: Reduce the risk of patient harm resulting from falls (hospital).**
- ✓ Assess and periodically reassess each patient's risk for falling, including the potential risk associated with the patient's medication regimen, and take action to address any identified risks.

2005 Hospitals' National Patient Safety Goals

- **Goal: Reduce the risk of surgical fires (ambulatory).**
- ✓ Educate staff, including operating licensed independent practitioners and anesthesia providers, on how to control heat sources and manage fuels, and establish guidelines to minimize oxygen concentration under drapes.

NPSG Evaluation & Scoring

- Apply to ALL accreditation programs
  - ✓ Includes All Full Surveys & Unannounced Surveys
- Must implement all goals/recs relevant to scope of services, or implement JC approved alternative
- Surveyors evaluate actual performance, not just intent
  - ✓ Are recommendations implemented & how consistently are they being done
- Expected track record from 1 Jan 03 to survey date
- Failure to address 1 or more recommendation, will result in a Recommendation for Improvement or a Supplemental Recommendation for Improvement.

How Can You Assist?

- **Become educated on AMEDD PS Program & roles/responsibilities in daily practice**
- **Report all close calls, adverse events & sentinel events**
- **Ensure patient/family educated on how they can participate to facilitate safe care**
- **Remain informed of safety alerts & implement identified safe/best practices**
- **Integrate JC PS Goals into daily practice**

AMEDD - Leading the Way!

Our Key to Success is MTF Program 'Execution'

We need each of YOU to
share your knowledge/expertise & become
active participants in clinical safety
to
transition to an environment of
Cooperation

Conclusion

Working together to

Make the Safest Way the Best Way!

Thank You!

Remember

This project is so important, we can't let things that are more important interfere with it.